M. Jodi Rell
Governor

State of Connecticut
Department of Developmental Services

Peter H. O'Meara
Commissioner

Kathryn du Pree
Deputy Commissioner

To: Employee Requesting a Reasonable Accommodation

From: Teresa Gonzalez, ADA Committee Chairperson

Re: How to Request a Reasonable Accommodation under ADA

Enclosed please find the Request for Accommodation under the Americans with Disabilities Act (ADA) Form. This form should be completed when an employee is requesting a reasonable accommodation under ADA in order to perform the essential functions of their job. Such request must have supporting medical documentation. This means that the employee has to provide information sufficient to show that they have a disability that impairs their ability to perform major life functions. Major life functions include but are not limited to: caring for oneself, walking, seeing, hearing, speaking, breathing, learning, working, and performing manual tasks.

The completion of the request for accommodation form should not be considered as an approval, but rather a document to initiate a review of your request. You should be notified of the decision in writing.

Please be advised that when an accommodation is granted, it will be exclusively for the employee's specific job assignment and work location at the time of the review. Approved accommodations may be subject to re-evaluation, for example, if there are changes in work assignments and/or work location, medical condition, and/or the essential functions of the job are impacted.

For more information and to start the review and the interactive process, please submit the completed Request Form with the supporting documentation required including: the state job description or functional description with the essential functions of your position assignment as identified by your supervisor and signed by your manager, and the medical statement (please refer to definition attached.)

The HR Director or designee reviews the documentation and consults with you, your supervisor, and manager of your need for reasonable accommodation. Your manager and supervisor will work with the HR Director or designee as to the reasonableness of the accommodation as part of the interactive process, and discuss operations impact, cost involved, and the possible accommodation that is most appropriate for both the employee and employer.

Please refer to relevant definitions attached and to the DDS Manual, Section: Affirmative Action, Procedure No: II.F.PR.005 for more information.

Phone: 860 418-6000 ◆ TDD 860 418-6079 ◆ Fax: 860 418-6001
460 Capitol Avenue ◆ Hartford, Connecticut 06106
www.ct.gov/dds ◆ e-mail: ddsct.co@ct.gov

Definitions:

1. Individual with a disability:
    - Has a physical or mental impairment that substantially limits one or more major life activities; or
    - Has a record or history of such an impairment; or
    - Is perceived or regarded as having such impairment.

2. A qualified individual with a disability:
    - Is able to perform the essential functions of a job, with or without reasonable accommodation.

3. “Reasonable Accommodation” means any modification or adjustment to the work environment, or circumstances under which a position is customarily performed, enabling a qualified individual with a disability to perform the essential functions of the position.
    - DDS will reasonably accommodate the known physical or mental limitation of an employee with a disability unless the accommodation would impose an undue hardship to the Department.

4. The Medical Statement certified by a medical professional must define employee’s disability, precise limitations imposed, and the expected frequency and duration of the disability.
    - Questions may be asked as to how this disability would substantially limit the employee’s ability to perform the essential function(s) of their job, with or without a reasonable accommodation.

State of Connecticut

DDS

Department of Developmental Services

REQUEST FOR ACCOMMODATION UNDER AMERICANS WITH DISABILITIES ACT

Employee Name:_____ Position Title:_____

Employee ID:_____ Hours of Work: _____

Region/Work Location: _____

Shift (circle one): (1) (2) (3)

In support of your request for an accommodation under the Americans With Disabilities Act, please provide the following information and attach the required medical certificate:

Nature of Disability:

_____

_____

_____

Does the impairment affect a major life activity? Yes ☐ No ☐

If *yes*, what major life activity(s) is/are affected?

☐Caring For Self ☐Interacting With Others ☐Performing Manual Tasks ☐Breathing ☐Working
☐Walking ☐Standing ☐Reaching ☐Thinking ☐Toileting ☐Hearing ☐Seeing
☐Speaking ☐Learning ☐Sitting ☐Lifting ☐Sleeping ☐Concentrating
☐Reproduction ☐Other: (describe)

_____

_____

_____

_____

Accommodation Requested:

_____

_____

_____

_____

_____

(Please use the back for additional information)

I understand that you may have questions about my request and may need to contact my medical provider. I hereby give you permission to do so: ____ Yes ____ No

Employee/Applicant Signature: _____ Date: _____

HUMAN RESOURCE DIRECTOR REVIEW:

ADA Definition Met: _____ Yes _____ No

Essential Functions Impacted:

_____
_____
_____
_____
_____
_____

Operations Impact:

_____
_____
_____
_____
_____

Cost Impact:

_____
_____

Recommended_____ Not Recommended_____

Comments:

_____
_____

_____ _____
(HR Director or Designee's Signature) **(Date)**

DDS ADA CHAIRPERSON REVIEW:

_____
_____
_____
_____
_____
_____
_____

Approved_____ Denied_____

_____ _____
(Chairperson's Signature) **(Date)**

Request for Accommodation (continued):

_____
_____
_____
_____
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_____
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_____
_____
_____

IMPORTANT NOTE:

If not approved, employee/applicant has right of appeal to:

DDS Director of Equal Opportunity
460 Capitol Avenue, Hartford, CT 06106
Telephone number: (860) 418-6115.

Attachments:

State job specification or functional description with the essential functions of the position assignment
Essential Job Functions Tool (completed by Employee's immediate Manager)
ADA Medical Provider Form

State of Connecticut

DDS

Department of Developmental Services

Medical Provider Report for ADA

Date:_____

Employee Name:_____

A person has a disability under the Americans with Disabilities Act (ADA) if the person has an impairment that substantially limits one or more major life activities.

The following questions may help determine whether an employee has a disability:

1. Does the employee have a mental or physical impairment? Yes ☐ No ☐

   If yes, what is the impairment?

   _____
   _____
   _____
   _____

2. Does the impairment substantially limit one or more major life activities?
   If *yes*, what major life activity(s) is/are affected?

   ☐Caring For Self ☐Interacting With Others ☐Performing Manual Tasks
   ☐Breathing ☐Working ☐Walking ☐Standing ☐Reaching ☐Thinking
   ☐Toileting ☐Hearing ☐Seeing ☐Speaking ☐Learning ☐Sitting
   ☐Lifting ☐Sleeping ☐Concentrating ☐Reproduction
   ☐Other: (describe)

   _____
   _____
   _____
   _____

3. Describe the nature, severity and anticipated duration of the impairment.

   ☐ Temporary (explain)

   _____
   _____
   _____

☐ Temporary but will take longer than normal to heal (explain)

_____
_____
_____

Anticipated healing period:

_____
_____

☐ Temporary with residual effects (explain)

_____
_____
_____

☐ Permanent

☐ Chronic (explain)

_____
_____
_____
_____

4. Please list any specific functional limitations resulting from the impairment.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

5. The employee's job description is attached hereto. How do the functional limitations listed above impact the employee's ability to perform the essential functions identified?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

6. If you answered “Yes” to question 1, are there any reasonable accommodations you would suggest that may enable him/her to perform the essential functions identified? If so, what suggestions do you have?

_____
_____
_____
_____
_____
_____
_____

7. Additional Questions/Comments:

_____
_____
_____
_____
_____
_____
_____
_____
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_____
_____
_____
_____
_____
_____

Name of Medical Provider_____ **License #**_____

Address _____ **Phone No.**_____

_____ **Fax No.**_____

_____ _____

Medical Professional’s Signature **Date**

M. Jodi Rell
Governor

State of Connecticut
Department of Developmental Services

DDS

Peter H. O'Meara
Commissioner

Kathryn du Pree
Deputy Commissioner

To: HR Director, Manager, Supervisor

From: Teresa Gonzalez, ADA Committee Chairperson

Re: THE AMERICANS WITH DISABILITIES ACT (ADA) PROCESS

The purpose of this process is to provide a method whereby employees may file a request for reasonable accommodations under ADA. The following are the steps that need to happen when an employee requests a reasonable accommodation under ADA:

1. On a form designed for the employees to request reasonable accommodations under ADA, employees will provide the necessary information about the accommodation they are requesting. All requests must provide complete information that clearly identifies the nature of the individual's disability and their specific limitations in performing the essential functions of the job, a complete medical statement, and the state official job description highlighting the essential functions of the employee's specific position (signed by the immediate manager).

2. Document is submitted to the HR Director or designee who reviews and makes recommendation on approval or denial. HR determination is made as to whether the individual meets the definition of the ADA. HR Director, prior to making a recommendation, must consult with division/unit manager and the employee for their input as to the essential job functions of the employee's job and reasonableness of the accommodation as part of the interactive process that must occur.

3. Document is then forwarded to DDS ADA Committee Chairperson in Central Office with any additional information, i.e., essential job functions of the position, medical statement, operations impact, cost study, etc. Incomplete request packages sent to CO will be returned to the regional HR Director or designee.

4. The DDS ADA Committee will consist of three members. The DDS Assistant Agency Personnel Administrator will act as the chairperson. The Committee will review and make a final determination on approval or denial of the request. The ADA Committee Chairperson then signs off on the document, sends original back to the region for filing and a copy to the employee, and the DDS Director of Equal Opportunity. HR Director or designee communicates with the employee's immediate manager.

5. In the event of a denial, an appeal of the decision may be made, in writing, to the DDS Director of Equal Opportunity, 460 Capitol Avenue, Hartford, CT 06106.

ESSENTIAL JOB FUNCTIONS TOOL
(To be completed by Employee's immediate manager)

Employee Name:_____ Position Title:_____

Employee ID:_____ Hours of Work: _____

Region/Work Location:
_____

Shift (circle one):
(1) (2) (3)

1. What four or five essential activities actually constitute the job (Why does the position exist)? What is the relationship between each task? Is there a special sequence which must be followed to complete the tasks?

   _____
   _____
   _____
   _____
   _____
   _____

2. Would removing that function fundamentally change the job?

   _____
   _____
   _____
   _____
   _____

3. How much time, approximately, is spent performing the function? What is the degree of importance to the overall job success?

   _____
   _____
   _____
   _____
   _____

4. What is the number of other employees available to perform the function or among whom the function can be given? If you cannot reassign the duty, explain why (e.g., duty is required of all employees in the area because of heavy/fluctuating workload, is required of all because the nature/organization of the work requires use of rotating shifts/teams and this limits flexibility of assignment, is required because there are no others who can be assigned the duty).

   _____
   _____
   _____
   _____
   _____
   _____

5. What is the degree of expertise (knowledge, skills, and abilities) required to perform the function (e.g., special training, license, or certification) upon entry to the job?

_____
_____
_____
_____
_____

6. Which tasks pose the greatest chances for errors if they are not completed on time or are not performed? What are the consequences (e.g., would result in direct risk of injury or death, significant cost to the agency, immediate and serious equipment damage, delays in service to our customers, or disruption of the work of other employees)?

_____
_____
_____
_____
_____

7. Is the setting in which the function is performed a critical part of the job and does it preclude particular accommodations?

_____
_____
_____
_____
_____

8. Additional Comments:

_____
_____
_____
_____
_____
_____
_____

_____ _____

(Signature of Manager) Date